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Transcription results:

CO - Chioma Onuoha

NF: Naomi F. Fields

JW: Jazzmin Williams

RK: Rohan Khazanchi, MPH

MO: Michelle Oguwole, MD

UE: Utibe Essien, MD, MPH

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| CO: 00:03 | Welcome, everyone, to a new episode of the Antiracism in Medicine Series for the Clinical Problem Solvers podcast, whereas always our goal is to equip our listeners at all levels of training with the consciousness and tools to practice antiracism in their health professions careers. This is a very special episode of our series today because it is for the Society of General Internal Medicine annual meeting. And the title of this episode is Moving Towards Antiracism in Medical Education. This is also a very special episode because I am joined by my team members here at the podcast. My name is Chioma Onuoha, and I'm currently a research assistant at the Johns Hopkins Center for Health Equity and will be a medical student somewhere next year. And I will leave it to my team to introduce themself, starting with Naomi. |
| NF: 01:05 | Good morning, everyone. My name is Naomi F. Fields. I'm currently a third-year medical student at the Perelman School of Medicine at the University of Pennsylvania, and I'll be applying into internal medicine - whoo-hoo! - this fall. |
| JW: 01:19 | Hi, everyone. My name is Jazzmin Williams. I am currently a third-year medical student at the University of California, San Francisco. I'm going to be taking a year off for research, and I'm planning to apply into dermatology next year. |
| RK: 01:35 | Hi, y'all. My name is Rohan Khazanchi, and I'm an MD/MPH student right now at the University of Nebraska Medical Center and the University of Minnesota School of Public Health. And I'm getting my MPH right now but excited to be applying into internal medicine or med-peds next year. |
| MO: 01:51 | Hi, everyone. My name is Michelle Ogunwole, and I'm a general internal medicine fellow at Johns Hopkins University. And I'm also a general internist in a hospital. |
| UE: 02:03 | Hey, everyone. Utibe Essien. I am a proud SGIM member, a general internist, and assistant professor of medicine at the University of Pittsburgh. |
| CO: 02:14 | Fantastic. Thank you all so much. We're going to dive right in with our first question. So, Naomi, I'm going to address this one to you. As we all know, medicine has an incredibly high barrier to entry. Some of the more obvious barriers are the expenses, the confusion of applying and interviewing, and the high potential for debt accumulation, as well as the perceived need for stellar grades and perfect extracurricular activities. I would love for you to speak to us about some of the less acknowledged barriers to entering medicine and how you've been able to confront them on your own journey within medicine. |
| NF: 02:52 | Yeah. Thank you for that question, Chioma. So for me, one of the major barriers has sort of been the culture of medicine and how that manifests as you sort of advance in your training and get more exposure to clinical settings. So of course, there are differences in culture in terms of ethnicity or background or even just regionally, where you grew up. If you grew up in California and you go to school in Boston, it's just going to be a little bit different for you. But on top of all that or underlying it is the sort of acculturation into medicine as a profession and as a career and just the ways of communicating and the ways of understanding each other, as professionals, that can be sort of difficult to pick up on. And it can be difficult to navigate, especially if you haven't had exposure to people who are physicians or people who are in the healthcare workforce. And that's on top of all the pressures of trying to do well on the wards, trying to do well on sub-I's or what have you and on and on as you are in residency and beyond. |
| NF: 04:04 | And so for me, I've found it helpful to connect with mentors who really sort of show me the ropes and can sort of give me the heads-up and with whom I can have honest reflection about what that process feels like and sort of how to walk the walk and talk the talk in order to be successful professionally. And then the flip side of that is connecting with people, being in spaces where I can kind of center within myself again and get grounded within my sense of self. Because when you're going through a sort of acculturation process wherein you're becoming adaptable and flexible, it's exciting because you're becoming more part of the workforce that you've worked so hard for. But it can also be a little bit disorienting as you sort of pivot 360 degrees within a workday. So that's sort of two-sided. Learning the ropes and also connecting back to myself has been really important for me in targeting that. |
| CO: 05:08 | Thank you. I love that answer. And I think it's particularly helpful for me during this time period. And kind of building on that same idea of the premedical-entry, pre residency-entry time period, how can premed students and students applying into residency identify programs that will actually prioritize health equity, prioritize being your full self and your general well-being while they are doing their training? And what are kind of the challenges that can be associated with finding a place that you can really call home? Michelle, I'm going to put that one to you. |
| MO: 05:44 | Sure. Thanks for that question. I think that this is such an important piece. And I think these decisions that students have to make and residents have to make about where they're going to train and where they're going to feel safe and able to bring their full selves, as you alluded to, are so important. I think the bigger kind of challenge is that you don't really, really know a place until you get there, right, to know whether what you see is what people call window dressings, like, are they just performing, or is it really something that is seeped into the culture of the institution? But I think that there are kind of clues and things that you can look for and people that you can talk to. And the kinds of questions I think I would be asking for myself as a student and even as a resident, if this is important to you, I would want to know things about how involved the community is with the institution and what effort the institution makes to involve the community, even at the medical school level, right. So do students have access to community members in a real way that informs their training that's embedded in the curriculum? Right? If advocacy is important to you, do you have an opportunity to do that as a student? Is it-- "celebrated" would be the best thing that you can ask for, right, but at the very least, are you given space to do that? And do you have people that you can look up to and you can see that they're doing those things, too? |
| MO: 07:19 | I think the curriculum piece, too. Is there some mention of social determinants of health? Or these broader issues that we know are so important to equity, how is that a part of the curriculum? I think now doing this work as a researcher, I sometimes have these moments where I'm just like, "Wow, I really wasn't exposed to this in medical school in a way that I wish I had this language," right. And I think we're seeing it more now that students are demanding that. And I think that's wonderful. And I think that there is an expectation that people know this work and this language around social determinants of health and equity, antiracism, all of those things. How much is that a part of the actual curriculum? |
| MO: 08:05 | And then I think the other important thing is, you walk into a place, and you want to be able to see yourself. I mean, I think that that can't be diminished. And for me, I remember looking up and not just saying, "Are there students that look like me?" That's great. But you start going up the pole, and you start to always see that dwindling effect, right, that as you go up in leadership, are you still able to see people that look like you? That was an important thing for me as a fellow, even, too, when I was looking around, especially if you're-- whether or not, actually, you hope to be in leadership, it's important for you to see yourself. I think there's other things, like, are there people dedicated to the work of diversity and equity? Are there positions for that? And I think that can go one of two ways. I think it's important when you see even in a medical school that there's a dean who focuses on diversity, equity, inclusion, or even now people are talking about somebody who focuses on antiracism and education. I think that that requires an investment from the institution. And so whenever I see that, at least I'm hoping that it's not a window dressing, but that it is showing me that the institution is committed to having a full position and office to look at these issues and make sure that it's happening across the board. I actually often look to see, if they are put in the same position as a dean of admissions or a higher role, right: is that person who's holding that position, are they seen as at the same level as these institutional leaders? Because that'll tell me a lot as well. |
| MO: 09:47 | And then I think there's little things that I didn't really think about when I was coming into institutions. We were so excited to be at these places to live out our dreams. I personally looked up the institution, but I didn't understand any of the historical context of the institutions that I was walking into, right. And so I think having a little bit of a sense of that and what the community feels about the institution and what those relationships are. As much as you can get that from talking to students, I think, is really important. And I think other things is, when you talk to the students that are there, obviously, you're talking to them about what their experiences have been around safety, around what happens when an unarmed Black man is killed by police? What is the response of the institution? Are people given space to reflect on that? I think all of those things are important. Being able to know that your leaders are thinking about the things that weigh heavily on you is quite important. And I think the other kind of historical piece I was thinking about is, we've seen these institutions kind of take down these statues and these portraits and these things that are painful historical relics. And I think to me, it's meaningful that an institution would do that. And it shows that they're at least willing to acknowledge that the history has been painful. And this is a small step in the right direction. And so I would ask people or the institution about things like that. And so I'll pause there, but. |
| CO: 11:29 | I think that's such a phenomenal answer. And I know I framed it as, "What should trainees look for?" But I think it could, honestly, be taken as, "What should institutions be doing to recruit URM students?" So thank you. I hope people are taking notes. I kind of want to shift over. You mentioned a bit about curriculum, Michelle. And for the next few questions, I kind of want to talk about what happens when you're actually in the classroom, when you are on the wards, when you're learning. And especially, on this podcast, we have really talked about how race-based medicine can be dangerous and the ways that it can hurt not only patients, but also the people who are giving them care. And so I'm going to put this to you, Utibe. And everyone, of course, is open to chime in. But what are some of the ways that racism and racist ideologies are taught to trainees and really ingrained into medical curriculum and medical teachings? |
| UE: 12:22 | Yeah. So that is a huge question. And fortunately, we have been blessed with some experts on the pod, like Dr. Tsai, our newest team member, and Dr. Eneanya and others who have kind of walked us through the dangers of the race-based curricula or race-based calculators, etc., that really continue to exist throughout our medical field. I'm now, sadly, almost 10 years away from graduating from med school, which is freaking crazy. But I think the same conversations that you all have been having over the last couple of years in your early medical training or on the wards are ones that I was having back when I was in med school. The disparities that would kind of show up slide after slide without necessarily providing the context for why Black men had more cardiovascular disease, Black men in our city, in the Bronx where I train, were dying earlier than their White counterparts, just continue to show up, right. And then we showed up to the wards, and any attempts to try and describe some of the reasons for those racial differences really involved biological differences, genetic factors, or various cellular mechanisms that perhaps will explain why there's more prostate cancer in Black individuals or more asthma in Latinx individuals in our communities. |
| UE: 13:49 | And so rather than emphasizing, describing, discussing, even touching on the racism that existed in the very communities where our hospitals and medical school were, we really focused or tried to focus on the biological. And so I think there, definitely, has been a danger for that over the last year. In particular, we've seen leaders in our space of antiracism and health equity really call this out for educators, for researchers, for folks who are building these curricula to finally step away from this. And we are hopeful, obviously, while we're doing the work we do on this pod, that the times are changing. But we know that this change is going to be slow. Like, just a couple of weeks ago, we saw another paper kind of supporting or suggesting that our colleagues are haphazardly removing race-based calculators from our medical fields. And we know that kind of some of that coded language suggests that folks think that we're doing this work in vain. But again, like has been already mentioned on the talk, we know that we are moving the conversation in a better direction. So I'll kind of leave it at that. |
| CO: 15:04 | Thank you. I think one of the real beauties of this podcast is, we literally do have people at every level of training, all the way from Utibe to me down here, not even started medical school yet. So it's really great to hear all that perspective. And I know a lot of the things that you've mentioned, sadly, haven't changed too much. And kind of along that line, Rohan, this is kind of a big question. But I'm going to put it to you. We know that many schools are starting to add social determinants of health as electives or courses that kind of briefly touch on the interaction of racism and health. However, for a lot of students who are in medical school, they recognize that these efforts are simply not enough. So for you, when you envision an ideal medical school education, an ideal curriculum, how do you see the integration of health equity, antiracism? And who do you think we should be learning about these topics from? |
| RK: 16:01 | Yeah. Chioma, that's a huge question, and I think that's the question that brought this podcast team together. So everyone in medical education already agrees that teaching social determinants is important. It's something we've got to do better. But I think the ways that we teach about it, as Utibe kind of mentioned in his answer to the last question, sometimes risks being ahistorical are missing out on the structural root causes. And part of this is, I think we get stuck in the ivory tower of academia. And the end result becomes that our medical trainees are learning about bias without necessarily understanding their own biases. They're learning about disparate health outcomes, but they're not recognizing the structural underpinnings of inequity. And they're maybe even lacking a framework for, "What do I even do? Where do I begin to improve care for marginalized populations?" Most of us want to do good by our patients, so we want the skills and tools to actually make an impact. |
| RK: 16:50 | So my opinion on this is that we need to move towards building structural competency, which is the idea that we should train physicians to recognize and address the intersections of race and class and clinical presentation and systemic etiologies of health inequity, right, of the root causes. And there's low-hanging fruit, which a lot of institutions have pulled off already, maybe throwing in a workshop on microaggressions, having learners take an implicit association test, maybe even having a few lectures about how racism operates to impact health outcomes. But I think that's kind of just a little wishy-washy. We can go deeper. So the harder question we have to ask ourselves is, "How do we actually impact biases and behaviors? How do we move beyond knowledge, skills, and attitudes to actually impact the way that we treat our patients?" It's harder to move beyond one-off workshops and lectures to actually longitudinalize the interventions. |
| RK: 17:38 | So I'll give you a quick example from my corner of the world about how my institution is working on this and how we're trying to get out of the ivory tower. And that's that we can take the principles we learn from community-based participatory research and community-engaged research and apply them to medical education. And we did this in Nebraska. We're not a champion or a leader in this space in a traditional sense. Our student body is, unfortunately, only 10% underrepresented in medicine. So we've got a lot of work to do. But the first thing we did was, we found our community engagement champions. We have folks at our institution who grew up in the neighborhoods around Omaha or who have done community-engaged work before. And we pulled together a diverse group of faculty and staff with experience and lived expertise. We leveraged their relationships, and we reached out to community stakeholders. And these folks ranged from the owner of a soul food restaurant that we all love eating at to the CEO of a Federally Qualified Health Center to the superintendent of the public school district my mom has taught for 20 years. So a really wide range of stakeholders were brought in for these conversations. |
| RK: 18:37 | And the first thing that we did was, we just taught students the foundation. We talked about Omaha. We said, "Where do we live? What's the city that we're actually going to be learning medicine in? What are the structural factors that have [driven?] health inequities throughout history? Why was our city redlined in the 1930s? And how does that relate to racial and economic segregation today? How does that relate to food deserts and lead poisoning and chronic disease and unemployment in certain neighborhoods in our city?" And then we just went to the community, and we let them do the teaching. So we pulled together a half-day event off campus. It was at the Highlander venue in North Omaha. It's a community center well known to our partners. And we just gave our community stakeholders a platform to share their lived experiences. And they talked about how they'd seen their neighborhoods crumble over generations. They talked about how their brothers and sisters were showing up to the ED in pain because of their sickle cell disease and they wouldn't get treated properly for it. |
| RK: 19:24 | But the other thing that I thought was even cooler was, they talked about the strength of their communities, right. They talked about how the owner of that restaurant I mentioned would close the restaurant early on Wednesdays so she could let her unhoused community members come in and have a warm meal, right. We heard from the leader of a public housing agency about how they had implemented on-site preventive medicine screenings for their residents. So there was a lot of examples of how our communities are already doing this work and opportunities for us as students to think about how we can partner better. So I mean, I guess the moral of my story here is, I think a lot of times we feel like we need a fancy framework or a really good Venn diagram progression thing to talk to us all about what the social determinants are. But sometimes all it takes is just giving our communities a little space to tell us the reality. And I think that's been something that I've seen have more an impact on the biases of my classmates than any implicit association test or microaggression workshop ever would. |
| MO: 20:25 | I was just going to add to that. That was awesome, Rohan. Thank you for sharing that story. I think the other thing that I have appreciated more being on this podcast, and touching on what Rohan said about the importance of history and the fact that we have this kind of-- we get this ahistorical education a lot of times in medicine. And part of it is, I think we're so interested in learning about science and medicine, we don't always understand how these other pieces are so important. And I can tell you just on this podcast, right, sometimes we have lawyers and we have historians and we have people who bring this other perspective and this other lens of what has happened in this country. And I think the bigger thing that this podcast has taught us-- and maybe people don't even know that when we're doing the work to build this podcast, a lot of it is questioning everything. And I think having that kind of attitude, even about the things that you learn and being in an environment, a space-- even that there's a curriculum that has space to question this knowledge that's put in front of you about sickle cell disease, about the way diseases present. |
| MO: 21:39 | There's this historical underpinning. It's about the way this country was set up and built that I personally didn't really understand, just learning it from physicians who-- we kind of learn from the same models, right. But not only is it so critically important to involve our community members. But also, it makes our education richer, I think, when we start to add people who have that kind of structural expertise, right. That's where the lawyers and the people who have that sense of history about how the laws in this country were created in justice, right. And then you juxtapose that with what you're learning in education, and then you start to see how these disparities really, really show up. And when you're looking at the patients in front of you, instead of saying, "You're Black, so now you're three times as likely to die in pregnancy," right, then you can start to recognize these other factors that come into play and stop blaming patients. And you're able to point out and kind of trace back, right, that this has been going on for a long time. And I think that's a really powerful thing. At least it was for me. And I was just putting that out there as a part of what I hope to see in our curriculum and where medical education could be. |
| RK: 22:57 | Yeah. I love that, Michelle. And just to kind of run with it a little bit, I think the point is, it's no accident that we have disparities. And we got to understand why they exist to know how we can dismantle them. And the other thing I think a lot about is, training in Nebraska, a big part of my medical education has been doing rural health work, has been going out to rural communities where I didn't grow up and I don't know a lot about, right. I grew up in Omaha. I didn't grow up in Hastings, where one of my best friends is from. And in the same vein, a lot of my classmates grew up in rural Nebraska, right, and came to Omaha and don't know anything about the city. So it's just, having that context really helped me, right. Having a best friend in my class who's from Hastings, Nebraska, prepared me before I went there because he could tell me what the lowdown was, he could tell me about the problems his community was facing. And in the same vein, I hope when folks move to Omaha now, getting to do this curriculum, they understand what our city's about, they understand what the people are about, and they get to know our patients before they're in the hospital at their worst, at rock bottom, right. We see one specific aspect of people's lives. And I think getting that bigger picture and understanding where our community is coming from can really make a difference. |
| MO: 24:01 | Yeah. And I'll say one other thing because I think there's this other idea around implicit bias, where they used to say that one way to work to overcome those is through positive primers. So like, you have these positive examples of people that help kind of negate the stereotypes that you once had. And I think that that could be a kind of discussion for another time. But I think what's more powerful than even that is this idea of individuation, that you see people as individuals. And I think this story, Rohan, that you just told about your classmates sharing their experiences and the same way you were talking about the community sharing their experiences, that that is one of the most powerful things, I think, that can dismantle some of these ideas that we have about people, right. So it's not just that-- it's so easy for us to be like, "This is a person on welfare. This is a person who has all these issues," except, no, "This is Sandra, and these are her kids. This is her family. This is the experience that she's had living in this part of town. And she has a whole-- she's part of this huge family." And I think it changes the way that we see people, we see our patients. And so I think that's important, too. |
| UE: 25:21 | We're going to mess around and get everybody to go to Nebraska for med school after this conversation. But I think, again, Rohan, thank you for sharing that story in that context. I think it's super useful and reminds us, like you said, that medical students are really leading a lot of this work, which is a problem for our future of medicine in some ways, right. We folks are paying hundreds of thousands of dollars to get this incredible training and, on the other side, are actually leading the work, which is why four medical students, almost-med students, are on this call right now teaching a huge society of internal medicine. It's why Lash Nolen is going to be giving one of the keynotes-- and plenaries, rather, for SGIM, is because we're actually now asking our students to teach us about how to be antiracist in our work. And so I think, A, that is problematic for our field. Of course, we want our medical field to no longer be as hierarchical as it is. But until we actually experience and value these efforts, whether it's through the way we actually test for them-- I put a comment in the chat that, "Until we see antiracism and health equity and this history come through on our Steps 1, 2, and 3 in whatever capacity, I do think that we're going to continue to have learners and faculty members push back against leading this work. And I think that's to the detriment of our patients." And so just something else for us to think about. Yes, it needs to happen in the classroom. But also, as we continue to think about how we evaluate students who are going into derm, IM, med-peds, whatever careers they are choosing, how can they actually find value in this work beyond some of these amazing electives that are coming out? |
| CO: 27:08 | Yeah. I think that's a beautiful segue into my next question, which really builds upon this. I think Rohan touched on this idea of, when you are not the majority when it comes to this health equity and antiracism work. And we know that when it comes to teaching and discussions of social determinants of health and antiracism, it's often kind of pushed as a niche interest, an elective course, somebody who's interested in public health, who's getting an MPP. However, how can we actually generate antiracism and equity efforts that aren't limited to one segment? We know that it really does transcend between all of medicine. How can medical educators engage all students as stakeholders? And Naomi, I'm going to turn that one to you. |
| NF: 27:57 | Yeah. I love this question because I love sort of problem-focused things that get us thinking about what we can do on the ground and, of course, what we've been talking about this entire time. So I love that we're continuing to keep our focus there. And as I was thinking about this, I kind of thought about it at a few different levels of how medical education is developed and administered. So the first thing that I thought about was the board exam writers and how, in many ways, they are medical educators because at the end of the day, the people who develop our curricula at our home institutions are going to reflect what they know is going to be the, quote-unquote, "classical presentation" on the Step 1, Step 2, and beyond. And so I think that there are people who are already doing that work to sort of revitalize and make more responsible the ways in which race and racism show up on board examinations. But I think continuing to do that work, continuing to push to break down those doors, is one key way because if they change it, everyone else is going to follow suit. And so that's sort of a way to encourage people to engage a stakeholder sort of by proxy. |
| NF: 29:13 | Another thing that I thought about was sort of better incentivizing the relationship between race, racism, health equity, and all the different sort of fields that one can be interested in within medicine. I'm thinking about the ways that people who want to be basic scientists and physicians, people who want to be internists, people who want to be ob-gyns, they're all looking to people who are already sort of doing what it is that they see themselves doing in the future. And so if on an administrative level or even on a level of discovery, in terms of journals and publications, there are incentives for responsibly identifying and responsibly reporting how race, racism, health equity shows up in that work, that will sort of translate into how those individuals to whom we are looking as trainees sort of navigate this sphere as it relates to what their area of expertise is. So basically, sort of giving the charge to the people that all of us are sort of looking toward as we shape our careers as medical trainees. |
| NF: 30:37 | Another thing that I thought about sort of-- and this builds on the point that Michelle just made about encouraging structural expertise. One thing that I found during my time here at Penn is that although people are approaching this space of racism, health equity work from different lenses-- like, I minored in African American studies is in college. Some people have never even heard of any-- they just are approaching it from a very different space. But I found that once people were sort of deeply educated on the ways in which racism surfaces within medicine and with the ways that our profession has played a role in propagating that and continues to and this sort of responsibility that we have to address and eradicate disparities, people, honestly, surprised me. I think that it happens because people who come into medicine, they have a heart to care for people, a heart to take care of others. And once you sort of turn that light on, I think we should give ourselves some credit that education could go a long way to sort of catalyze a spark that will just sort of light that fire of engagement. I think that sometimes there's a narrative that people simply don't care or they are just willfully ignorant. And maybe that's true sometimes. But I would like for us to give each other more credit in committing to that deep education. I think that can do a lot for people, as well. |
| JW: 32:22 | Yeah. I think I just really resonate with a lot of what Naomi just mentioned. And I think there's a lot to say about the-- well, one of the points that Naomi just mentioned is the difference in expertise between certain students who might have majored in these things in college or who are just stepping forward into medical school for the first time. That's something that can't be ignored. And so I think that either not having a curriculum or having it just be an elective isn't acceptable because at the end of the day, we're all going into medicine. We're all going to take care of patients and need this sort of fundamental knowledge. So I think it's imperative for folks who are designing undergraduate medical education curriculum to keep that in mind and realize that teaching about social determinants of health and health equity is really just foundational, just as much as the pathophysiology of nephrotic and nephritic syndromes are. It's essential to our professions. And so having a sort of base, foundational curriculum is very important, and also having that curriculum taught by experts. |
| JW: 33:38 | This is kind of a difficult topic sometimes. But I find that in medicine, a lot of times people like to look for expertise within the field and from other physicians. But sometimes physicians aren't always the ones who have this knowledge because it hasn't been promoted in our field for so long. And it's okay to step outside of the ivory tower of medicine and ask the legal scholars or the sociologists or the critical race theorists or even the community members to come and be a guest lecturer, be a panelist, a patient panelist, or something like that to provide that education that's so foundational to our care. And then not just stopping at having this be a few-week course or a block in the curriculum, but really making a lot of care into weaving this throughout the curriculum and showing how, as you're learning about cardiovascular disease-- that you're going through and talking about all of the social determinants of health and how they play a role in impacting patients' health so that people don't have that opportunity to sort of check out or don't have an opportunity to not draw connections between certain diseases and the factors that influence them. |
| CO: 35:00 | Absolutely. Absolutely. I think you both have made such great points. And Naomi made a very specific point about, when we get into these spaces, we are looking up to people who have been through it before, people who are already in the professions that we're looking at. And a big part of that is really just how we retain people who have diverse interests, including health equity and antiracism. And, Jazzmin, you put it so well that we really do have to broaden who we're going to look at, who we're going to consider our leaders. And so I kind of want to build on that and direct this next question to you. As we know, it's difficult for some to attract Black and Brown URM talent, but it's another thing to retain it. And many people of color find themselves in medicine and find themselves paying a sort of minority tax, where a lot of their time is put into these diversity efforts, into these antiracism efforts that they are so passionate about. However, it takes away from their curricular work. It maybe takes away from their ability to do the kind of studying that's required to actually make it through these difficult spaces. So, Jazzmin, whose duty is it to you to kind of restructure these medical curriculums? And how should this labor actually be recognized? |
| JW: 36:21 | Yeah. And I think Utibe touched on this a little bit earlier. Medical students are paying money to come here and be taught all of this knowledge. I think it's pretty clear that the burden of the responsibility doesn't actually lie on the medical students, even if we may be more advanced in some of these topics than people who are our current faculty. I think the people who are employed to teach or to run medical schools are responsible for their curriculum work. And I think that it's everyone's duty in medical education to become educated on these topics because we, as students, are learning right along with you. And in times when decisions need to be made and people don't feel like they have the capacity or the resources to make these types of informed decisions, I think it's perfectly valid to hire outside help, whether they're diversity, equity, and inclusion consultants or just as Rohan's institution is doing and creating their curriculum alongside our community experts. These are the types of things that our leadership can do to really make sure that they're making robust decisions when designing these curriculum courses. |
| JW: 37:51 | And I think that by sort of relieving some of that burden-- because a lot of us students of color feel that if we're not going to be advocating for this work, that it's just not going to be done. And so I think if that burden can be taken away from students, then many of us who already find fulfillment in this work can be able to engage in it more with less desperation, ultimately, which is what contributes to a lot of burnout in my experience and experience of many of my friends. And so then I think that when students are actually getting involved with this work, recognition is so important. We're starting our careers. We are, as you mentioned, Chioma, taking time away from our studies to do this work. And so I think it needs to be adequately recognized. And so payment is always best, but that's not always an option for institutions. And so in most cases, I think it's perfectly reasonable to just get creative with things and either come up with titles that people can put on their CV and really speak to letters of recommendation, obviously. Or even something that's been pretty creative at my institution that I've been able to take a part of is being put on a publication and being an author on a publication about some of our curriculum work or even doing presentations on some of our curriculum advocacy work. So there's a lot that can be done to really compensate trainees and encourage this work. Yeah. So that's what I have to say about that. I don't know if anyone else has any thoughts. |
| UE: 39:38 | Yeah. I was just going to say, Jazzmin, thank you, yeah, for dropping those practical tips because this is what people are looking for, right. People are going through emails. It's not just at the medical student level. I'm sure Michelle can speak to this, as well, is that any Black faculty member on campus right now or person of color is getting hit up like crazy for all of these issues, like, "Guys, we just realized racism exists, and we need to diversify our curriculum. Can you please help with this? I know you're not an educator. I know you are a researcher and actually don't ever talk to medical students. You're up in the lab 80% of your time. But we actually just need you to teach us how to teach about racism right now." And like you said, just, the medical students, I think, are also kind of feeling this anxiety around it. The faculty members are, as well, and saying if they don't have a Black face in front of this, they're probably going to do it incorrectly, or they're not going to have that same kind of historical perspective that I may be able to bring in either from my own personal experience or from my major in undergrad or my graduate studies. And we've seen that happen time and time again with our colleagues in other publications. We're seeing just the lack of nuance that folks are having around these conversations around racism and structural racism, etc. |
| UE: 40:59 | And so we are all kind of in this battle together. The 5% of physicians that are faculty members that are Black, 5% that are Latinx, and the even fewer that are coming from our American Indian and Alaskan Native groups, we're really all kind of struggling to figure out, how can we represent our work? And Dr. Manning stated beautifully on her episode of the podcast - Episode 6, I think it was - that her representation doesn't come without taxation, and that taxation are those late nights that she's putting together slides and those weekends that she's recording podcasts with us. And so all of us are feeling this, whether it's a premedical student about to get up in her journey like Chioma, all the way to a full professor of medicine like Dr. Manning, like Dr. Corbie-Smith. And they are all sharing their experiences. And so we know, A, this is not just unique to each and every one of us. It's not unique to one medical school versus the other. And I think in order for us to really sustain this work, we have to listen to those practical tips that you gave us, which, again, I appreciate, and again, just acknowledge that we've not done a great job at this so far and we've got to find a way to promote it in academia. At the end of the day, in an organization like SGIM, many of us are coming to it from academic spaces. And as we look through our promotion packages as faculty members, for example, what's on that package are the number of papers you can publish, are the teacher evaluations that you get. It's the number of grants that you get, big and small. It's not how many classes you taught about antiracism. And we're sadly seeing a lot of backlash towards that, which I know we're going to talk on a little bit. So again, this is a broader systemic issue and structural issue that I think we need to take on. |
| RK: 42:45 | Yeah. I'm going to throw one more thing out there, which I think is something that Jenny and I talk a lot about what the podcast team, which is that positionality matters a ton. So I mean, Jenny and I are both part of this antiracism crew. It's awesome to be in this space. And we also recognize that we both come in as non-Black people of color. We're allies to this work in many ways. And I think the reality in most academic institutions is that the folks who have the power to give better incentives to their faculty and their trainees to kind of put these resources out there tends to be folks who look like Jenny and I or folks who are, honestly, more often than not, White male faculty members. And so I think this is difficult, right, because it calls for allyship, it calls for giving up power to give somebody else resources. And I think that's a hard conversation that, hopefully, we're getting to a point where we can be having it more openly at institutions around the country because we got to support folks. We got to keep them around to do this important work. We know this matters to our patients. We know this matters to our colleagues. And part of that work is being good allies. |
| MO: 43:51 | I was going to piggyback off of this because there's so much good stuff here. I love what Rohan spoke about, positionality. And yeah, we're going to keep plugging our episodes. So I'm like-- Dr. Camara Jones spoke about this, too, and actually called not just for allyship, but coconspiratorship, which means that you actually have to make this active choice that you are going to have to put something on the line. It requires, I think, a choice that you're putting down your privilege and you're handing it to somebody else in some ways. And I think that that is a difficult thing. But it's so critical to this work. And the other kind of thing that I heard. I heard Jazzmin talk about this a little bit, and Naomi, too. But I think about, "How are we going to sustain this feeling that's going on, this moment where people feel like this work is so important?" And Utibe just said, "Oh my gosh, racism exists." I think for a lot of people, they have felt during this pandemic, during this time in history, like this is a huge problem, even though so many of us have lived in this kind of reality and know it has been. So how do we sustain those efforts? And I think it does take an investment in this work and not just these one-offs. Or like Utibe mentioned, you can pull faculty. There are people who are really doing this work as scholarship, and how are we really getting them involved in this work, truly? |
| MO: 45:26 | And kind of a bigger analogy, I think, about the way quality improvement and patient safety showed up in medicine. And there was this idea about quality and safety. There was a huge Institute of Medicine report, To Err Is Human. And what happened is, the medical field was kind of horrified by the fact that there are all these mistakes happening and it was costing people their lives. And so you see this huge push in quality and safety, right. It becomes part of the medical curriculum. And I did training in quality and safety. And when we were learning how to teach this, one of the things that we talked about is that this can't become one of those things that we do our work-- and then we think about the quality improvement and patient safety project. When you go to work, quality and safety is the work that you do. It's alongside the work that you do, right. So whenever you're doing your work to diagnose and treat, you're actually supposed to be thinking about safety and quality at that same moment. How do we get there with this kind of work? I mean, these are the questions that I have too, right. |
| MO: 46:29 | So kind of those feelings of being horrified by the errors and the fact that patients were dying, we argue that racism kills, right. That's the point. And so I think a lot of us are saying who do this work, this work is so close to our hearts, right, "Where is that same energy," right, "for this work?" I think when we get to that level of, "This cannot stand. People cannot die needlessly through these systems and structures," then it becomes an issue of, it can't just be tacked on to the work that we do. It has to become embedded in all that we do as clinicians, as scientists, as researchers, right. |
| MO: 47:11 | And then I think the flip side of that is, what happens is that the institutions don't see this as just this extra thing that they're going to have to expend money on occasionally, right. But it's a true investment, right. And so people say we don't have the funding to pay people to do this work or bring in experts. But I think that you pay for what you value, and if there's repercussions for that the way there is for quality and safety, right, there's errors, that stuff doesn't stand anymore. There's never events that you just-- it can't happen in your hospital. There's huge penalties for that. I think that those are the things that we're needing to see to make sure that this movement and this energy is kind of sustained over the long haul, so. |
| NF: 48:01 | And I'll just add one thing really quickly that I thought of because as we've been talking a lot about people sort of giving away some of their privilege or sharing some of their power, it reminded me of another of Dr. Camara Jones's sort of widely used quotes, but something that she also repeated in her conversation with us, was the reminder that, "Racism saps the strength of the whole." And the reason why I think about that when we bring up privilege and power is because I think part of the problem is, there's a paradigm that centers individual privilege, individual sort of advancement and success, which is sort of the Western paradigm with which we all have to, honestly, sort of battle, living in this country. And I think that shifting our view to recognize that racism is sapping the strength of the whole makes it easier to sort of endorse that altruism that will just sort of propel us to share that "power," quote-unquote, and will propel us to do the work that will help us to eradicate racism not only within our institutions, but also within the communities around us. That quote always just reminds me that if racism is operating as it was designed to in these systems and in these structures, there are people who are not sort of living their full potential, honestly, and we are missing out on that as a society. And so I think that keeping that vision in mind and keeping that sort of as a center, as a grounding point, can help us to sort of reconceptualize how we're thinking about sharing, quote-unquote, "privilege and power." |
| CO: 49:44 | Absolutely. Such fantastic points all around. And we have come to about the end of our conversation. One last question kind of to end on that I'm going to pose to you, Utibe, is really just that, what do you say to people who are interested in medicine or interested in health equity, but they're hesitant about battling with the oppression and the struggle that may come with a profession that really has its roots in White supremacy? Where do you find your hope, and what do you say to others? |
| UE: 50:15 | Yeah. I'm sure that's something that all of us could share about, I think. Since this is a SGIM audience, a place where I personally have found hope, is this group. So having a community like the SGIM Health Equity Commission, where we have incredible women like Dr. Corbie-Smith and Dr. Susana Morales, Dr. Cristina Gonzalez, mentors of mine over the years who have demonstrated, like Naomi mentioned at the top of the conversation, what a future in medicine can look like, has definitely given me hope just to get to see those stars rise and kind of imagine what my life can look like in this job. But I think, like you said, Chioma, there are oppressions and there are hardships. There are the 5 years of training where I felt like I couldn't even literally say the words "Black Lives Matter," much less have a podcast on antiracism be a part of our medical education, wondering about what that kind of retribution would be on the fellowship application process and the faculty application process, etc. And I know I wasn't alone in those fears. |
| UE: 51:21 | And so while there is some hope, there definitely is the concern that I think about, especially early career folks kind of thinking about pursuing this career. But people need us. I don't think there ever will be another moment like we're in right now, where the world is realizing just how much equity matters, just how much the work that we're doing matters. And folks just don't have the level of skill, expertise, nuance, shared or lived experiences around these conversations. And so for all the folks early on in their career, still thinking and wondering about whether or not they want to go into it, we need you. The patients need you. Your communities need you. We all need you in this work. And again, I am hopeful that just the conversations that we're having right now - again, shout out to Lash who's going to be giving the plenary tomorrow at this amazing conference - just demonstrates that we are starting to see the tide shift towards addressing and moving towards antiracism in our medical education. |
| CO: 52:26 | Wonderful. Well, I want to thank all of you so much. Thank you to SGIM for hosting us today. We have to, of course, shout out the podcast, Clinical Problem Solvers: Antiracism in Medicine. You get to hear from not only these voices, but so many more, including our team members who aren't here, and a bunch of phenomenal experts who will talk about everything from global vaccine equity to police violence and its interaction with medicine and health. So thank you all. Thank you to everyone who watched and listened. And we hope that you really got some depth out of this because I know I did and I always do whenever I get to sit down with this group. So thank you, everyone. |